

## GUIDE TO COMPLETING CMS (HCFA) FORM 1500

<b>Billing Information</b>	<b>Location on CMS (HCFA) Form 1500</b>
VCP Claim Number	1A
Claimant Name	2
Claimant SSN	1A – Include Claim Number
Claimant Date of Birth	3
Claimant Address and Telephone Number	5
Provider Billing Name (Payee), Mailing Address of Payee and Telephone Number of Payee (Including Area Code)	33
Treating Licensed Therapist or Supervising Therapist's License Number	33 or 24K if Another Therapist's Name and License are Already Listed in 31 and 33
Treating Licensed Therapist or Supervising Therapist's Signature or Signature Stamp, and Date	31(below payee name and address) 24K if another Therapist Name and License are Already Listed in 31 and 33.
Intern's First and Last Name and License or Registration Number	24K
Tax Identification Number (TIN) of Payee: SSN/ FEIN	25
Dates of Service	24A
Description of Service	24D
Revenue Code	N/A
Procedure Code – CPT Number	24D
Type of Mental Health Service: Individual, Family, Group, Telephone, Medical Management, etc.	Determined by CPT code in 24D
Place of Service: Home or Office	24B
Diagnosis Code	24E
Patient Account Number	26
Billed Amount	24F and 28
Amount Paid By Patient or Insurance	29
Insurance Information	4, 7, and 11 or 9
Facility Where Services Were Rendered (Not Payee)	32
Medicare Payer Identification Number (ZZ#)	33